

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35988
STATE FILE NUMBER
149 Primary Registration District No. 1002 Registrar's No. 4552

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>5900 SWOPE PARKWAY</u> INSTITUTION <u>SWOPE PTWY NURS. HOME</u>		d. STREET ADDRESS (If outside, give location) <u>3516 SUMMIT STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>EVANS</u> Middle <u>R.</u> Last <u>MCGARVEY</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-11, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>MEXICO, MISSOURI</u>	
13a. FATHER'S NAME <u>JAMES E. ROSS</u>		13b. MOTHER'S MAIDEN NAME <u>MIRIAM WARREN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>493-12-61440</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Artery Thrombosis</u> <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>due to (b) Hypertensive Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive Arteriosclerosis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <u>11:45</u> Month, Day, Year <u>Nov 1954 to Sept. 1957</u>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from Death occurred at <u>Nov 1954 to Sept. 1957</u> and last saw her alive on <u>9/28/57</u>		22a. SIGNATURE (Deceased or title) <u>Robert W. Hamill MD</u>	
22b. ADDRESS <u>4620 J.C. McPherson</u>		DATE SIGNED <u>9/30/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>OCT-1-1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>D.W. NEWCOMERS SONS</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>		25. DATE RECD. BY LOCAL REG. <u>10-1-57</u>	
26. REGISTRAR'S SIGNATURE <u>neva mitchell</u>			

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2



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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Vern Lawler

Licensed Embalmer No. 4915
P. O. Address 478 32nd

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.